

EXHIBIT D

Coosa County Inmate Medical Intake Sheet

11/13/2003 17:24:42 MEDICAL SCREENING FORM

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Booking No: 030000601 Date: 11/13/2003 Time: 16:50 Type: NORMAL
 Agency to Bill: COOSA COUNTY Facility: COUNTY JAIL

Inmate Name: KELLEY DANIEL BRYAN Race: W Sex: M
 DOB: 06/17/1971 Age: 32 SSN: 420 25 6528 Height: 6'01" Weight: 190

- N 1. Is inmate unconscious?
- N 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?
- N 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?
- N 4. Any signs of poor skin condition, vermin, rashes or needle marks?
- Y 5. Does inmate appear to be under the influence of drugs or alcohol?
- N 6. Any visible signs of alcohol or drug withdrawal?
- N 7. Does inmate's behavior suggest the risk of suicide or assault?
- N 8. Is inmate carrying any medication?
- N 9. Does the inmate have any physical deformities?
- N 10. Does inmate appear to have psychiatric problems?
11. Do you have or have you ever had or has anyone in your family ever had any of the following?
- | | | |
|-----------------------|----------------------------------|------------------------------|
| <u>N</u> a. Allergies | <u>N</u> f. Fainting Spells | <u>Y</u> k. Seizures |
| <u>Y</u> b. Arthritis | <u>N</u> g. Heart Condition | <u>N</u> l. Tuberculosis |
| <u>Y</u> c. Asthma | <u>N</u> h. Hepatitis | <u>Y</u> m. Ulcers |
| <u>N</u> d. Diabetes | <u>N</u> i. High Blood Pressure | <u>N</u> n. Venereal Disease |
| <u>Y</u> e. Epilepsy | <u>Y</u> j. Psychiatric Disorder | <u>Y</u> o. Other (Specify) |

Other: ASTHMA - ALBUTEROL SCHITZOPHRENIC/BI-POLE
ARTIFICIAL VERTEBRAE IN BACK

12. For females only:

- a. Are you pregnant?
- b. Do you take birth control pills?
- c. Have you recently delivered?

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COOSA COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

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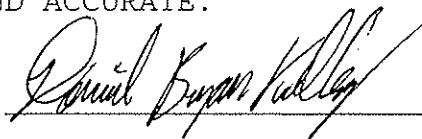
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- Y 13. Have you recently been hospitalized or treated by a doctor?
- Y 14. Do you currently take any non-prescription medication or medication prescribed by a doctor?
- Y 15. Are you allergic to any medication? CODEINE
- Y 16. Do you have any handicaps or conditions that limit activity?
- Y 17. Have you ever attempted suicide or are you thinking about it now?
ATTEMPTED SUICIDE 6 mos AGO
- Y 18. Do you regularly use alcohol or street drugs?
- Y 19. Do you have any problems when you stop drinking or using drugs?
- N 20. Do you have a special diet prescribed by a physician?
- N 21. Do you have any problems or pain with your teeth?
- N 22. Do you have any other medical problems we should know about?

I HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE:



DATE:

TIME:

BOOK OFFICER:

DATE:

TIME: